GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 6, 2023

Hope Lovell
LoveJoy Special Needs Center Corporation
17101 Dolores St
Livonia, MI 48152

RE: License #: AS780413488
Investigation #: 2023A0584044
State Road Home

Dear Ms. Lovell:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS780413488
Investigation #:	2023A0584044
Complaint Receipt Date:	08/17/2023
Investigation Initiation Date:	08/17/2023
Report Due Date:	10/16/2023
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17101 Dolores St Livonia, MI 48152
Licensee Telephone #:	(517) 574-4693
Administrator:	Hope Lovell
Licensee Designee:	Hope Lovell
Name of Facility:	State Road Home
Facility Address:	10860 State Road Morrice, MI 48857
Facility Telephone #:	(517) 574-4693
Original Issuance Date:	10/01/2022
License Status:	REGULAR
Effective Date:	03/31/2023
Expiration Date:	03/30/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff block off the entrance to kitchen to prevent Resident A access.	Yes
Direct care staff Veronica Ostipow forcefully pushed Resident A out of the kitchen.	No

III. METHODOLOGY

08/17/2023	Special Investigation Intake - 2023A0584044.
08/17/2023	Special Investigation Initiated - Email with Ardis Bates, Shiawassee Health and Wellness Recipient Rights officer.
08/23/2023	Contact - Face to Face Interviews at Shiawassee Health and Wellness center with direct care staff Veronica Ostipow, Samantha Rogers, Skye Ember, Jessica Wilbert, and Janae Spencer.
09/08/2023	Inspection Completed On-site interviews with Resident A, B, C, D, E, F and home manager, Shelby Morse.
10/5/2023	Exit conference with Licensee Designee Hope Lovell.

ALLEGATIONS:

- **Direct care staff block off the entrance to kitchen to prevent Resident A access.**
- **Direct care staff Veronica Ostipow forcefully pushed Resident A out of the kitchen.**

INVESTIGATION:

On 8/17/2023, the Bureau of Community and Health Systems (BCHS) received the above allegations via the online complaint system.

On 08/23/2023 at the Shiawassee Health and Wellness office with Recipient Rights Officer Ardis Bates, I conducted face to face interviews with direct care staff Veronica Ostipow, Samantha Rogers, Skye Ember, Jessica Wilbert, and Janae Spencer. Ms. Ostipow stated she was working with Ms. Spencer and noticed that two chairs were blocking the entrance to the kitchen because Resident A has a habit

of touching burners or hot pans when trying to grab food. Ms. Ostipow stated that during a shift a couple of weeks ago, she did not place the chairs in the entrance of the kitchen. However, she was aware they were there. According to Ms. Ostpow, she noticed Resident A pushed past the chairs and entered the kitchen while Ms. Spencer was cooking dinner. Ms. Ostipow stated she was guiding Resident A out of the kitchen when he caught his foot on one of the chairs in the doorway and stumbled as a result. Ms. Ostipow denied the allegation she forcefully pushed Resident A, and stated that when he moves fast, he can lose his balance.

Ms. Rogers, Ms. Ember, and Ms. Wilbert all stated that either placed the chairs in the entrance to the kitchen area at meal preparation time to prevent Resident A access to the kitchen, and/or witnessed other staff members do this. They all stated they did not witness or hear of the allegation that Ms. Ostipow forcefully pushed Resident A out of the kitchen area.

Ms. Spencer confirmed that a couple of weeks ago, while she was cooking for the residents, she witnessed Resident A stumble and almost fall while Ms. Ostipow was helping him leave the kitchen area. Ms. Spencer stated she saw Ms. Ostipow's hand on Resident A's back when he stumbled which appeared to her to not be accidental. However, she could not say for sure if Ms. Ostipow intentionally pushed Resident A.

On 9/8/2023, I conducted an unannounced investigation at the facility and observed Residents A, B, C, D, E, F, who were all unwilling or unable to answer my questions. Residents A, B, C, D, E, F all appeared in good health and were well groomed. The facility was neat, clean and in good repair. I did not observe any chairs placed in the entrance area to the kitchen or any other barriers inhibiting resident movement.

Shelby Morse, facility home manager, confirmed staff members were placing chairs in the entrance area to the kitchen because Resident A has a habit of rushing into the kitchen and grabbing hot pans on the stove top. Ms. Morse stated that as a result of learning that this intervention inhibits Resident A's movement, they are seeking other solutions and/or interventions with Resident A's case manager to protect Resident A from possible injury while in the kitchen.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members it has been established that staff members were constructing barriers to prevent Resident A's movement in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members, there is not enough evidence to substantiate the allegation that Ms. Ostipow forcefully pushed Resident A when directing him to leave the kitchen area.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/5/2023, an exit conference was conducted via email with licensee designee Hope Lovell notifying her of the findings of the investigation.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes in the status of this license.

10/5/2023

Candace Coburn — Date
Licensing Consultant

Approved By:

10/6/2023

Michele Streeter — Date
Area Manager